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Instructions for Completion

Fill-In Instructions

NOTICE OF TERMINATION OF LIABILITY

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P.O. Box 30016, Lansing, Michigan 48909

INSTRUCTIONS: SEE REVERSE SIDE

1. Employer Federal ID Number

Click Here to Start

2. Name of Business(es)

3. Owner of Business (if applicable)

4. Business Address (Street Number and Name)	City	State	ZIP Code

5. NAIC Carrier ID Number (9 digits)	6. ZIP Code of Issuing Office	7. Name of Insurance Company

8. Policy Number	9. Effective Date of Termination

10. The policy is cancelled and all business names and addresses operating under the Federal ID Number listed in Item #1 are terminated for the following reason:

- ☐ A. Non-payment of premium
- ☐ B. Employer insuring elsewhere
- ☐ C. Employer no longer in business
- ☐ D. Employer uncooperative
- ☐ E. Other (provide reason) _____

Failure to maintain required insurance may subject the employer to a fine of $1,000.00 per day and imprisonment up to six months.

Pursuant to the Workers' Disability Compensation Act, this is to certify that the insurance company carrying the workers' compensation insurance on the above referenced employer has terminated its liability as indicated.

11. Authorized Signature:	Date:

Authority:	Workers' Disability Compensation Act of 1969, 418.621(2)(g); R 408.41a
Completion:	Mandatory
Penalty:	Failure to file is punishable under MCLA 418.631

Purpose of Form BWC-401:
To notify the Michigan Bureau of Workers' Disability Compensation of the termination of a policy issued to an employer.

A separate BWC-401 should be filed for each Federal ID number being cancelled in the policy.

When required:
Must be filed with the Bureau at least 20 days prior to the effective date of termination.
Only one copy should be filed with the Bureau.
A copy must be mailed to the employer.
Must be used to terminate all coverage for the employer.

INSTRUCTIONS FOR COMPLETION

Item #1 — Employer Federal ID Number
Enter the employer Federal Identification Number or Social Security Number shown on the Form BWC-400. This number is **required** on all Form BWC-401 filings.

Item #2 — Name of Business
Enter the name(s) of the business(es) which are to be cancelled from the policy. If all names and address of the business are to be cancelled, list only the primary employer name and address, the owner name, and complete Item #10.

Item #3 — Owner Name
List the complete name of the corporation, partnership, individual, joint venture, or public employer which owns the business. If Item #2 is identical to Item #3, leave Item #3 blank.

Item #4 — Business Address
List the main address of the business to be cancelled (including City, State and ZIP Code).

Item #5 — NAIC Carrier ID Number (9 digits)
National Association of Insurance Commissioner's (NAIC) ID number (5 digits) followed by the group number (4 digits) of the insurance company.

Item #6 — Zip Code of Issuing Office
Place the complete zip code for the insurance carrier office issuing the form. This zip code number will be used on all correspondence sent by the Bureau to the designated contact person for each carrier.

Item #7 —Name of Insurance Company
The full name of the insurance company.

Item #8 — Policy Number
Enter complete policy number. Maximum 20 digits.

Item #9 — Effective Date of Termination
Intended date of termination. Numeric (Month/Day/Year)

Item #10 — Policy Cancelled and Reason for Termination
Complete only if all business names, divisions and addresses are to be terminated. Check only one reason for termination.
Check **A** if policy is cancelled for non-payment of premium.
Check **B** if employer is insuring elsewhere.
Check **C** if entire employer operating under this Federal ID Number is out of business.
Check **D** if policy is cancelled due to employer being uncooperative.
Check **E** if termination is for any other reason. Please note the reason.

Item #11 — Authorized Signature
Must have an original signature in black or blue ink. Typed signatures are not acceptable. Include the date the form was signed.

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Form #	BWC-401	Form Name:	Notice of Termination of Liability

When Required:

When terminating or canceling a workers' compensation policy issue to an employer. The form will be filed 20 days before the effective date of the termination or cancellation.

Required Fields:

Forms submitted without the following required fields completed will either be returned or a letter will be generated asking for this information:

1, 2, 4, 5, 6, 7, 8, 9, 10, 11

Instructions:

Completing the Form:

- ✔ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✔ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✔ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✔ Press Tab to accept the field change and go to the next field, or
  Press Shift + Tab to accept the field change and go to the previous field.
- ✔ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✔ To print the form, be sure to use the printer button on the Acrobat toolbar menu instead of your web browser's print function. You may need to select the “Print as image” option in the print dialog box to print the completed form.

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

How to Submit This Form:

- ✔ Print the completed form
- ✔ Sign the form
- ✔ Make a copy for your records
- ✔ Send a copy to the employer
- ✔ Send the original of the signed Form 401 to:

Bureau of Workers’ Disability Compensation
P O Box 30016
Lansing MI 48909